PATIENT INFORMATION

Name____ DOB ____________

Address______________________City___________State________ZIP__________

Cell Phone______________Home Phone________________E-Mail_________________

Employer_____________________Primary Dr.______________Referred by___________

Primary Insurance_____________________ ID__________________Group___________

Secondary Insurance___________________ID__________________Group___________

Do you give us permission to contact you via phone, email, and mail to leave you detailed messages regarding any tests or results (please circle one)? **YES** **NO**

What are your interests (Check all that apply)?

- ⇨ Skin Tightening
- ⇨ Varicose Veins
- ⇨ CoolSculpting/SmartLipo
- ⇨ Joint Pain/Stem Cell Therapy
- ⇨ Skin Exams
- ⇨ Tattoo Removal
- ⇨ Laser Hair Removal
- ⇨ Scar Revision
- ⇨ Skin Resurfacing
- ⇨ Facial Redness/Veins
- ⇨ Spider Veins
- ⇨ Botox/Filler
- ⇨ Hormone Replacement Therapy
- ⇨ Other:____________

Do you have any allergies? ____

Are you taking or have taken any of the following in the past?

- ⇨ Blood Thinners
- ⇨ Advil, Aleve
- ⇨ Aspirin
- ⇨ Vitamin E
- ⇨ Antibiotic
- ⇨ Bleaching Cream
- ⇨ Topical Steroids
- ⇨ Retin A
- ⇨ Fish oil
- ⇨ St. John's Wart
- ⇨ Accutane
- ⇨ Antivirals
- ⇨ Gold Therapy
- ⇨ Garlic/Gingko/Ginger
- ⇨ Birth Control

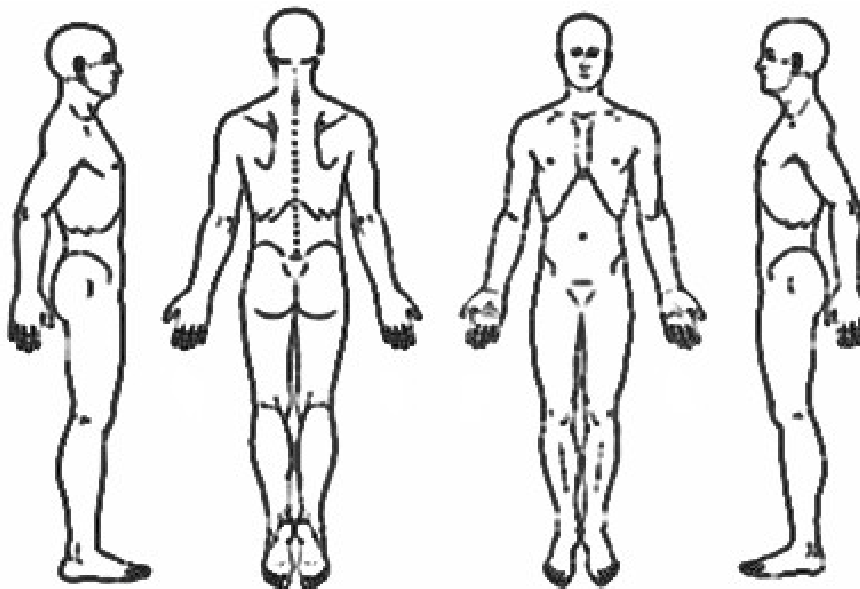
Have you ever had any of the following?

- ⇨ Skin Cancer
- ⇨ Cystic Acne
- ⇨ Cold Sores
- ⇨ Rosacea
- ⇨ Eczema
- ⇨ Deep Sun Burns
- ⇨ Psoriasis
- ⇨ Melasma
- ⇨ Allergic Skin Reaction
- ⇨ Collagen Disorder
- ⇨ Suspicious Skin Legions
- ⇨ Keloid/Hypertrophic Scar
- ⇨ Vitiligo
- ⇨ History of Substance Abuse
- ⇨ History of Sexual Abuse
- ⇨ Heart Condition
- ⇨ Diabetes
- ⇨ Anemia
- ⇨ Bleeding Disorder
- ⇨ Clotting Disorder
- ⇨ Hepatitis or HIV
- ⇨ Neurologic Disorder
- ⇨ Marfans/Lupus

How did you hear about us? Friend/Referral__________________________($50 Credit for Patient)

- ⇨ Google/ Search Engine
- ⇨ Building/Sign
- ⇨ Facebook/Instagram
- ⇨ ValPak/ Mail
- ⇨ Insurance
- ⇨ YouTube

Please indicate the area(s) of concern on the following diagram:



Do you currently have any of the following (Check all that apply):

Skin

- ⇨ Mole Changes
- ⇨ Change in Hair/Nails
- ⇨ New Lesion
- ⇨ Itching
- ⇨ Dryness
- ⇨ Rash

Eyes

- ⇨ Cataracts
- ⇨ Vision Change
- ⇨ Glaucoma
- ⇨ Redness
- ⇨ Pain

Ear Nose Throat

- ⇨ Voice Change
- ⇨ Dentures
- ⇨ Hoarseness
- ⇨ Sinusitis
- ⇨ Tinnitus
- ⇨ Canker Sores

Respiratory

- ⇨ Asthma
- ⇨ Bronchitis
- ⇨ Cough
- ⇨ Breathing Problem
- ⇨ Shortness of Breath

Cardiovascular

- ⇨ Chest Pain
- ⇨ Coronary Artery Disease
- ⇨ Ankle Swelling
- ⇨ HTN
- ⇨ Palpitations
- ⇨ Cold Extremities

Gastrointestinal

- ⇨ Bowel Changes
- ⇨ Constipation
- ⇨ Diarrhea
- ⇨ Heart Burn
- ⇨ Hemorrhoids
- ⇨ Nausea/Vomiting

Genitourinary

- ⇨ Change Stream
- ⇨ Hernia
- ⇨ Hesitancy
- ⇨ Impotence
- ⇨ Frequent Urination
- ⇨ Lesions
- ⇨ STD’s
- ⇨ Urgency

Musculoskeletal

- ⇨ Arthritis
- ⇨ Decreased Motion
- ⇨ Gout
- ⇨ Injuries
- ⇨ Joint Pain
- ⇨ Joint Stiffness
- ⇨ Swelling

Psychiatric

- ⇨ Anxiety/Depression
- ⇨ Agitation

Female Reprod.

- ⇨ Vaginal Discharge
- ⇨ Vaginal Dryness
- ⇨ Painful Intercourse
- ⇨ Irregular Periods
- ⇨ Menopause
- ⇨ Breast Pain
- ⇨ Breast Lumps
- ⇨ Breast Discharge
- ⇨ Pelvic Fullness/ Discomfort

Endocrine

- ⇨ Hot/Cold Intolerance
- ⇨ Neck Enlargement
- ⇨ Temperature/Chills
- ⇨ Decreased Sex Drive

Neurologic

- ⇨ Decrease in Concentration
- ⇨ Decrease in Memory
- ⇨ Dizziness
- ⇨ Headache
- ⇨ Numbness
- ⇨ Seizures
- ⇨ Tremor

General

- ⇨ Weight Gain
- ⇨ Weakness
- ⇨ Fatigue

HIPAA Notice of Privacy Practices

This notice describes how healthcare information about you may be used and disclosed and how you can access this information. Our commitment at Colorado Skin Care is to serve our patients with professionalism and care to protect the privacy and security of all Protected Health Information. If you would like a copy of our complete Notice of Privacy Practices, please ask any staff member.

During the course of serving your interests it may be necessary to share information with other healthcare providers and/or business associates. The following are examples where information may be shared.

- Medical information may be used to show that a patient needs certain care, treatment, and services (such as lab tests, prescriptions, treatment plans, and research study requirements).
- For payment purposes, we may use a billing service.
- We may disclose Protected Health Information to another provider for treatment (such as, referring doctors, or specialists)
- We may send claims to your insurance company containing medical information. We might also contact their utilization review department to receive precertification (approval for treatment in advance).
- We may use your photographs for patient/provider education. (see below)
- We may share your health information with a person whom is involved in your medical care of payment for your care, such as your family member or a close friend. We may also notify your family regarding your location and health condition.

If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

Consent to Use Photos/Release Information

I, ____________________________________ DOB: ___/___/___, hereby give David Verebelyi MD and/or his staff, permission to use my photographs and protected health information in the following manner. **Please note that all identifying information will be removed from photos**. (Please initial all that apply):

__________ I only want my photos used in the medical chart and nowhere else

__________ My photos may be used in the physician's office to show other patients "before/after" pictures

__________ My photos may be used for medical education/lectures to other physicians

__________ My photos may be used in professional writing which may include textbooks, journals, etc.

__________ I authorize unrestricted use of photographs, (privacy will be maintained)

__________ I authorize the release of information to healthcare providers and other organizations to facilitate care

If you are not available at the time of call, please list individuals (designees) which we may discuss your care and medical information. This person (designee) will also be able to contact our office regarding your information.
Designee_______________________________________Relationship_______________Phone____________

Patient/Guardian Signature:____ Date: _____________

Clinic Policies

Late/No Show Policy

Please be advised that you are expected to arrive 10 minutes prior to your appointment time to allow for check-in and registration.

If you arrive later than your scheduled appointment time, you may be asked to re-schedule or be seen as a walk-in if there is a provider available.

If you are unable to make your appointment, please call and re-schedule so that other patients can be accommodated. If you do not show up for your appointment and do not call during business hours to cancel at least 48 hours prior to your appointment, you will be considered a No Show. There will be a $50.00 No Show fee charged to your credit card. **We require a credit card on file and will charge a $50 NO Show fee if you miss your appointment.**

Deposits and Packages Initial__________

Some procedures may require a $500.00 deposit which is due when surgery is scheduled. Payment in full is required one week prior to your scheduled surgery date**. All deposits and packages are non-refundable**. Under certain circumstances the deposit may be applied to other services **ONLY** if the original procedure is cancelled or rescheduled more than one week prior to the surgery date.

For vascular procedures billed through insurance, a credit card will be held on file. If your appointment is for a surgical procedure you may be charged up to 20% of the TOTAL cost. YOU MUST cancel 7 business days prior to the surgery to avoid this fee.

Co-payments and Deductibles

Your co-payment is required as part of a contractual agreement between you and your insurance company and will be collected prior to seeing the provider.

If you have not met your deductible and are having an in office surgical procedure, we will collect the deductible amount required prior to your surgery. Any overages paid will be refunded to you. (Note: the deductible is the out of pocket amount required before insurance will pay out any insurance claims)

Laboratory testing

A provider may need to rely on results of laboratory testing to determine a diagnosis and course of treatment. We perform a few simple laboratory tests in office. However, some tests may need to be sent to an outside lab for further examination. **You will receive a separate bill** from the laboratory for which you will be responsible.

______________________________ ______________________________ ____________________

Patient Name Responsible Party Signature Date